2011 RHC/FQHC

PROVIDER TRAINING

RHC/FQHC Components

- Billable components under program
  - Encounter Visits
  - KIDMED Screening Services
  - EPSDT Dental
  - Adult Denture Services
  - Expanded Dental Services for Pregnant Woman (EPSPW)

RHC/FQHC Components

- OB Service Encounter
  - Must bill T1015 w/TH modifier
  - Encounter with TH modifier is not counted towards the outpatient service limits for recipients 21 years of age and older
- Dental Encounter D0999
  - Can be billed in relation with T1015, T1015-TH and T1015-EP
  - All claims billed using D0999 must include supporting detailed procedures on the 2006 ADA claim form

Obstetric Ultrasound Service Limits

- Effective October 15, 2011 two ultrasounds shall be allowed per pregnancy (270 days).
- Includes ultrasounds performed by all providers regardless of place of treatment.
- Additional ultrasounds may be considered when medically necessary and must be submitted with the appropriate documentation.
- CPT codes 76811 and 76812 are restricted to maternal fetal medicine specialists.

Billing for Social Workers

- Currently you must enter the RHC/FQHC group as the attending and billing provider in 24J and 33b
- Social Workers are currently not allowed to enter their individual provider number

Billing Reminder

- Only the encounter code and periodic screenings are billed on KM-3 (hard copy) or 837P with the K-3 (KIDMED) segment (electronically)
- The encounter code and immunizations, laboratory tests, interperiodic screenings, consultations, and low level visits are billed on the CMS-1500 (hard copy) or on the 837P (electronically)

CommunityCARE

- The state's comprehensive health plan is based on a primary care case management model.
- In most cases the recipient is linked to a PCP.
- Current CommunityCARE policy remains unchanged.
- However, Community Care as we know it will be going away with the implementation of CCN/Bayou Health, or April 30, 2012.

Multiple Medical Encounters

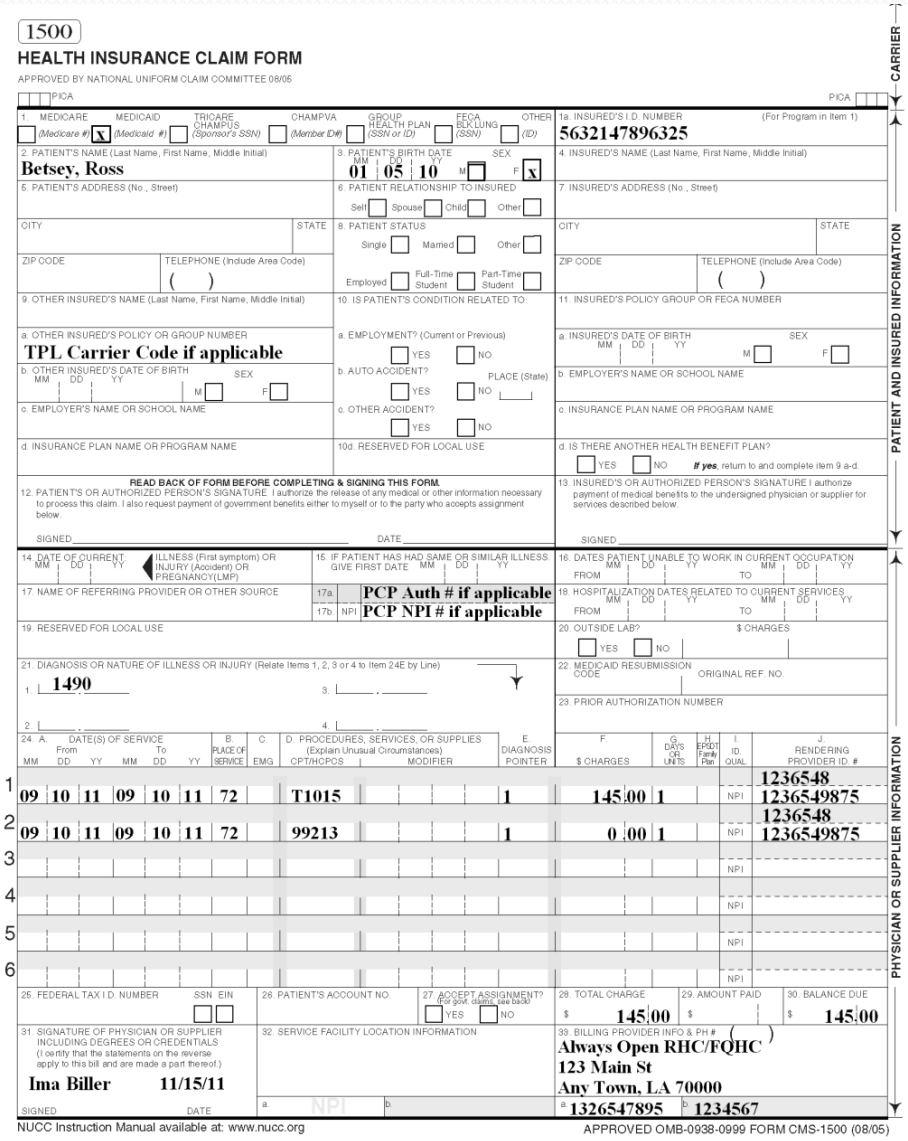
- Multiple medical encounters with more than one health care practitioner or with the same health care practitioner, which take place on the same day at a single location, constitute a single visit, except for cases in which the recipient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

- Claims for same day unrelated visits should be sent to the Correspondence Unit with a letter of explanation and documentation to show that these services meet the medically necessary guidelines.

RHC/FQHC Claim Filing

- CMS 1500 claim form
  - If encounter code is missing, detail lines will deny
  - If encounter code is denied, detail lines will deny
  - If encounter passes edits, encounter rate is paid and detailed lines pay at $0
  - Detailed lines can be either $0 or Usual and Customary fees
  - All detailed procedures must be covered services under Louisiana Medicaid RHC/FQHC program

Example of CMS 1500 w/Encounter



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) [x] MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 5632147896325

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Betsey, Ross

3. PATIENT'S BIRTH DATE MM DD YY: 01 05 10 SEX M [ ] F [x]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL Carrier Code if applicable

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a PCP Auth # if applicable

17b NPI PCP NPI # if applicable

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 1490 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	09 10 11	09 10 11	72		T1015		1	145 00	1		NPI 1236548 1236549875
2	09 10 11	09 10 11	72		99213		1	0 00	1		NPI 1236548 1236549875
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 145 00

29. AMOUNT PAID $

30. BALANCE DUE $ 145 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Ima Biller 11/15/11

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Always Open RHC/FQHC
123 Main St
Any Town, LA 70000

a. 1326547895 b. 1234567

CARRIER

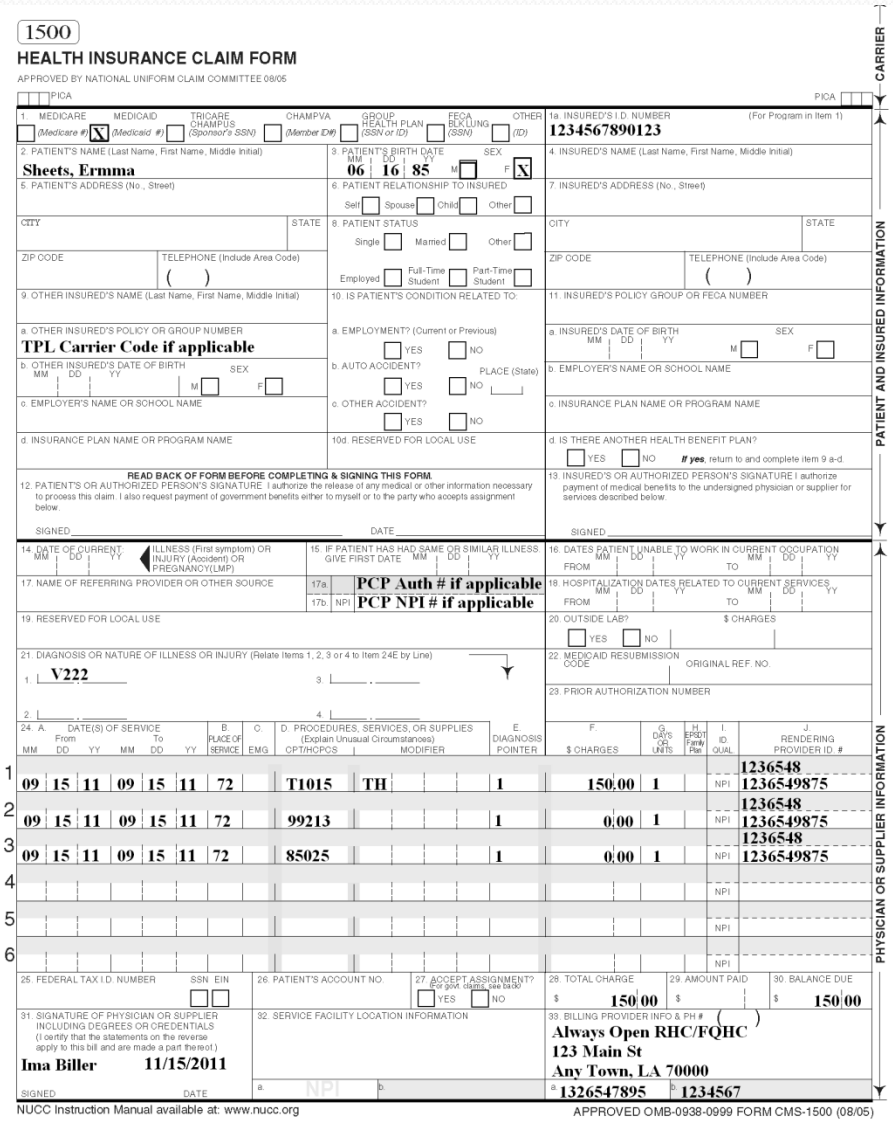
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Example of Pregnancy Encounter



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 1234567890123

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Sheets, Ermma

3. PATIENT'S BIRTH DATE: 06 16 85 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER: TPL Carrier Code if applicable

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. PCP Auth # if applicable

17b. NPI PCP NPI # if applicable

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. V222 3. _____ 2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	09 15 11 | 09 15 11	72		T1015	TH	1	150 00	1		NPI	1236548 1236549875
2	09 15 11 | 09 15 11	72		99213		1	0 00	1		NPI	1236548 1236549875
3	09 15 11 | 09 15 11	72		85025		1	0 00	1		NPI	1236548 1236549875
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 150 00

29. AMOUNT PAID $

30. BALANCE DUE $ 150 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Ima Biller 11/15/2011

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Always Open RHC/FQHC
123 Main St
Any Town, LA 70000

a. 1326547895 b. 1234567

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

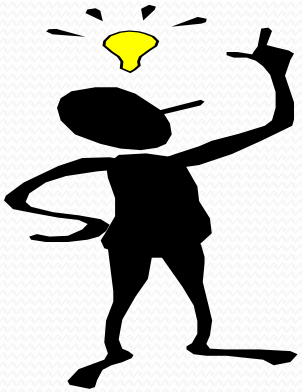
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ADJUSTMENTS AND VOIDS Molina 213

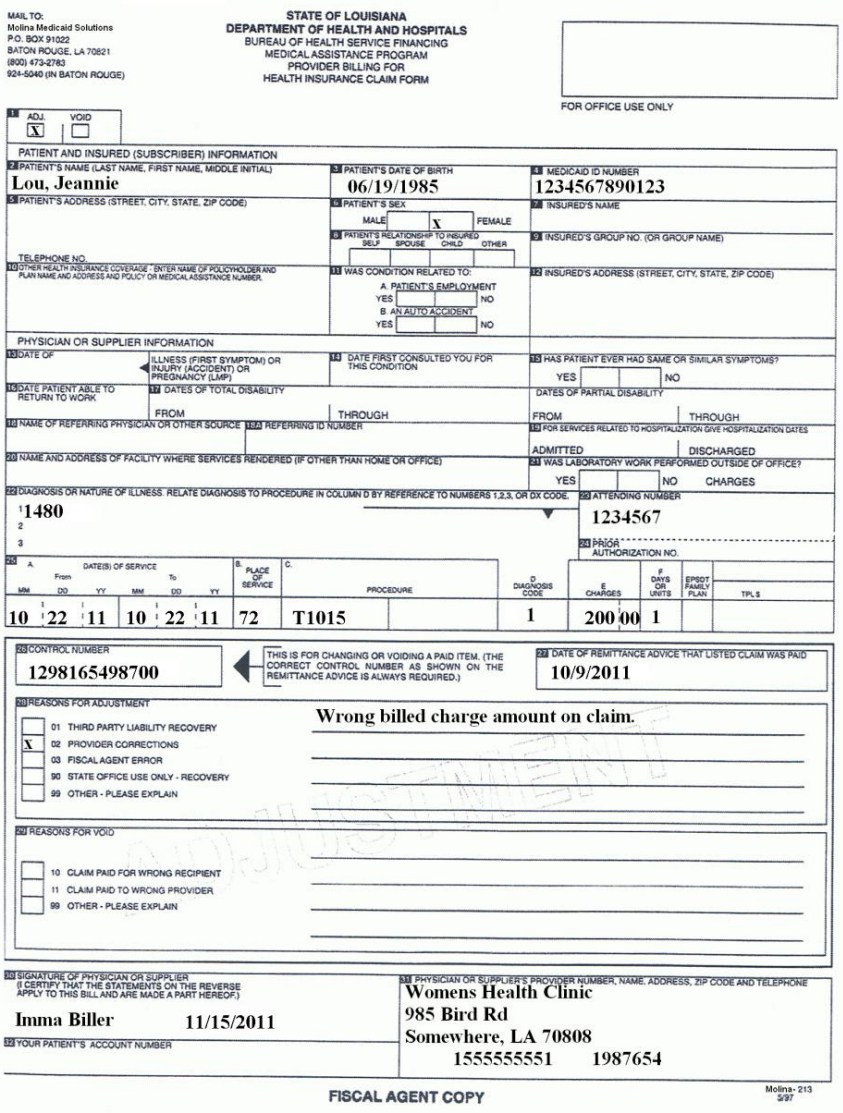
ADJUSTMENT - complete the Molina 213 form with information exactly as it appeared on the claim form EXCEPT for the information you wish to adjust

VOID - complete the Molina 213 form with information EXACTLY as it appeared on the original claim form.



*REMINDER - only a paid claim can be adjusted or voided.

Adjustment/Void Form 213



MAIL TO:
Molina Medicaid Solutions
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
924-5040 (IN BATON ROUGE)

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICE FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
HEALTH INSURANCE CLAIM FORM

FOR OFFICE USE ONLY

1. ADJ. [X] VOID [ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

2. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Lou, Jeannie
3. PATIENT'S DATE OF BIRTH: 06/19/1985
4. MEDICAID ID NUMBER: 1234567890123
5. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.
6. PATIENT'S SEX: MALE [ ] FEMALE [X]
7. INSURED'S NAME
8. PATIENT'S RELATIONSHIP TO INSURED: SELF [ ] SPOUSE [ ] CHILD [ ] OTHER [ ]
9. INSURED'S GROUP NO. (OR GROUP NAME)
10. OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER
11. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT YES [ ] NO [ ]
B. AN AUTO ACCIDENT YES [ ] NO [ ]
12. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

PHYSICIAN OR SUPPLIER INFORMATION

13. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
14. DATE FIRST CONSULTED YOU FOR THIS CONDITION
15. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES [ ] NO [ ]
16. DATE PATIENT ABLE TO RETURN TO WORK
17. DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
18. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
18A. REFERRING ID NUMBER
19. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
20. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
21. WAS LABORATORY WORK PERFORMED OUTSIDE OF OFFICE? YES [ ] NO [ ] CHARGES
22. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1,2,3, OR DX CODE.
1 1480
2
3
23. ATTENDING NUMBER: 1234567
24. PRIOR AUTHORIZATION NO.

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. PROCEDURE	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	EPSDT FAMILY PLAN	TPL'S
10	22	11	10	22	11	72	T1015	1	200 00	1		

25. CONTROL NUMBER: 1298165498700
THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)
26. DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID: 10/9/2011

26. REASONS FOR ADJUSTMENT
Wrong billed charge amount on claim.
[ ] 01 THIRD PARTY LIABILITY RECOVERY
[X] 02 PROVIDER CORRECTIONS
[ ] 03 FISCAL AGENT ERROR
[ ] 90 STATE OFFICE USE ONLY - RECOVERY
[ ] 99 OTHER - PLEASE EXPLAIN

27. REASONS FOR VOID
[ ] 10 CLAIM PAID FOR WRONG RECIPIENT
[ ] 11 CLAIM PAID TO WRONG PROVIDER
[ ] 99 OTHER - PLEASE EXPLAIN

28. SIGNATURE OF PHYSICIAN OR SUPPLIER (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)
Imma Biller 11/15/2011
29. YOUR PATIENT'S ACCOUNT NUMBER

31. PHYSICIAN OR SUPPLIER'S PROVIDER NUMBER, NAME, ADDRESS, ZIP CODE AND TELEPHONE
Womens Health Clinic
985 Bird Rd
Somewhere, LA 70808
1555555551 1987654

FISCAL AGENT COPY

Molina-213
5/97

Crossover Procedures

- Recipients with both Medicare and Medicaid
  - Copy of claim filed to Medicare on the UB-04
  - Attach Medicare EOB to claim (copy must be legible)

- If claims are not submitted in this order, the claims will be returned unprocessed

KIDMED Linkage

KIDMED Linkage:

- In order to obtain KIDMED linkage, providers MUST CALL AHS to verify the screening provider of record for the date that screening is being rendered.
- AHS – (800) 259-4444
- Specifically ask about the KIDMED Screening Provider

KIDMED Screening Policy

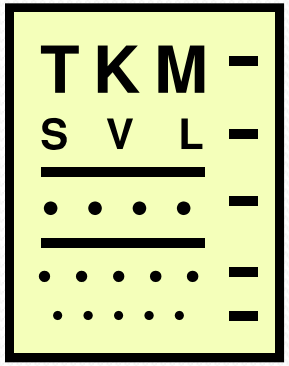
Medical Screening

- Must perform all 5 components
- Providers must use the age appropriate code in order to avoid claim denial

Note: Providers should use the TD modifier to report a screening that was performed by a nurse (RN or NP).

KIDMED Screening Policy

VISION SCREENING

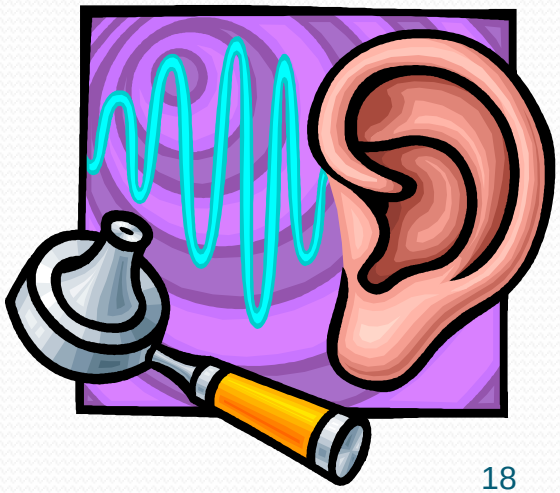


- Subjective vision screening
- Objective vision screening
  - Begins at age **4**
  - Bill with procedure code **99173** with the **EP modifier**

KIDMED Screening Policy

HEARING SCREENING

- Subjective Hearing screening
- Objective Hearing screening
  - Begins at age **4**
  - Bill with procedure code **92551**



KIDMED Periodicity Policy

- Periodicity Chart
- Off-Schedule Screenings
  - Bringing children up-to-date on screenings
    - Children under 2 years of age must be 30 days apart
    - Children 2 thru 6 years at least 6 months
  - Off Schedule screenings are not interperiodic screenings

Interperiodic Screenings

- Must be medically necessary
- Must be requested by parent, medical provider or someone that comes into contact with child outside of formal healthcare system
- If age appropriate medical screening is indicated, interperiodic screening should not be billed

Interperiodic Screenings

- Must include all 5 screening components
- Reason for referral, party requesting the screening, and outcome of screening must be documented
- Well Diagnosis is not required
- No limit to number of interperiodic screenings
- Periodic screenings must be up-to-date to perform interperiodic

Interperiodic Screenings

- Providers should use age appropriate procedure codes

MODIFIERS

TS = Interperiodic

TD = Nurse (RN or NP)

- Must be billed on CMS 1500 with w/T1015

Diagnosis & Treatment

- Providers must follow up to verify child keeps appointment and receives the services
- Chart must be documented that follow up was completed
- You must make at least two good faith efforts to re-schedule and have a process in place to document the efforts

Diagnosis & Treatment

Referring Recipients for Services

- Necessary referrals should be made at the time of screening if possible.
- Providers are responsible for discussing referral options with parents or guardians

WIC Referrals

- If the WIC referral is not completed at the time of an encounter and the recipient returns solely for the completion of the form, the RHC or FQHC can not bill separately for this service as no medical service has been rendered.

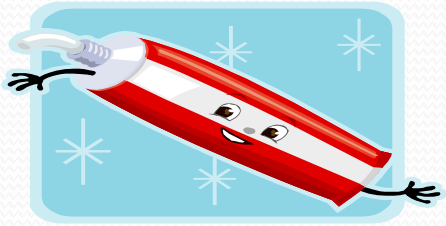
Adjustments & Voids
KM-3 Form

- Used to **correct** information on **PAID** claims
- For **adjustments** – complete the form as the claim **should have looked** originally
- For **voids** – complete the form **exactly as the original claim** that was submitted
- Indicate **reason code**
- Indicate **ICN** of **paid claim**

KIDMED Hotlines

- CommunityCARE/KIDMED AHS Hotline
  - (800) 259-4444
- Specialty Care Resource Line
  - (877) 455-9955
- TTY Hotline for Hearing Impaired
  - (877) 544-9544

Dental Services



- <u>Dental Encounter Code Usage</u>
  - EPSDT
    - Covers recipients under 21
  - Adult Denture Services
  - EDSPW (Pregnant Women)
    - Women 21-59 years of age
    - Coverage ends at delivery or pregnancy ends
- 2006 ADA Claim Form

LSU Dental School

LSU Dental Medicaid Unit

P.O. Box 19085

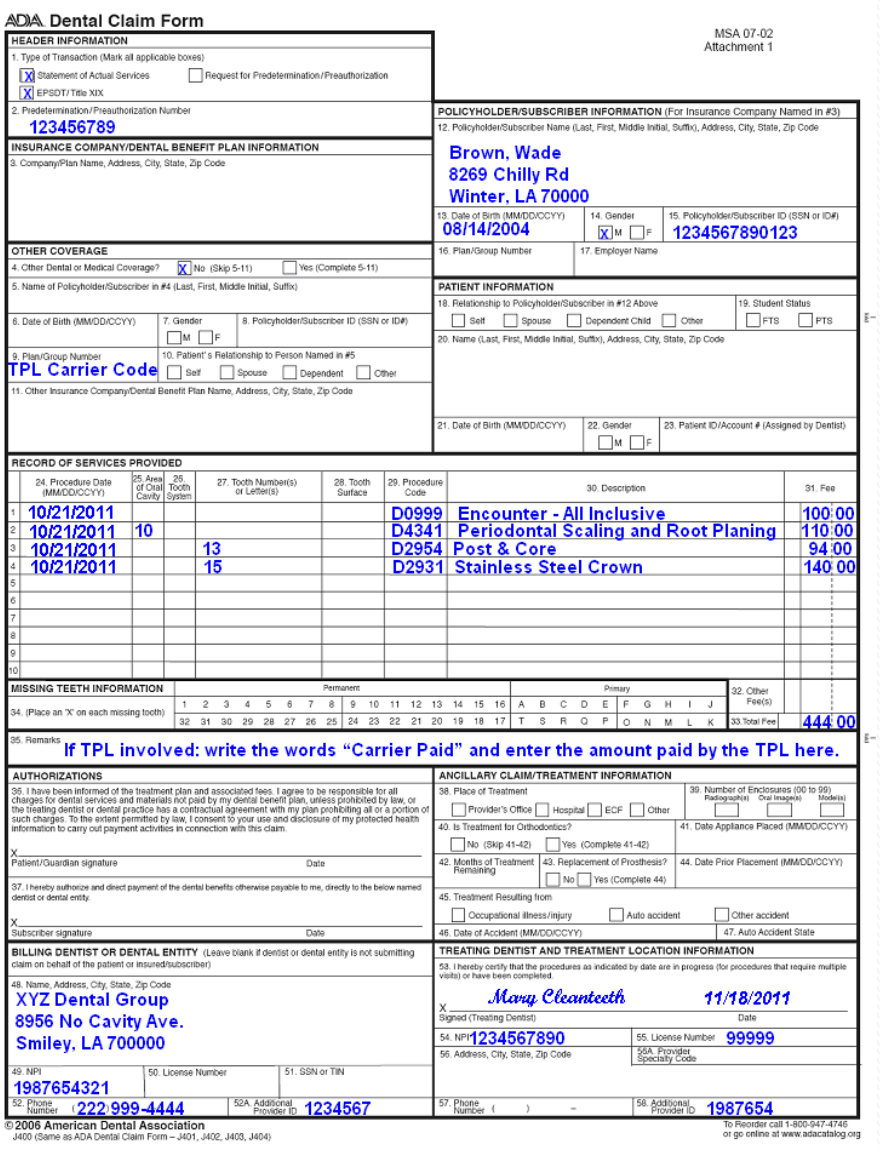
New Orleans, LA 70179-9085

(504) 941-8206

or Toll Free

1-866-263-6534

Completed ADA Claim Form



ADA Dental Claim Form

MSA 07-02
Attachment 1

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
[X] Statement of Actual Services [ ] Request for Predetermination/Preauthorization
[X] EPSDT/Title XIX

2. Predetermination/Preauthorization Number: 123456789

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? [X] No (Skip 5-11) [ ] Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number: TPL Carrier Code
10. Patient's Relationship to Person Named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:
Brown, Wade
8269 Chilly Rd
Winter, LA 70000
13. Date of Birth (MM/DD/CCYY): 08/14/2004
14. Gender [X] M [ ] F
15. Policyholder/Subscriber ID (SSN or ID#): 1234567890123
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [ ] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Student Status [ ] FTS [ ] PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender [ ] M [ ] F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	10/21/2011					D0999	Encounter - All Inclusive	100 00
2	10/21/2011	10				D4341	Periodontal Scaling and Root Planing	110 00
3	10/21/2011			13		D2954	Post & Core	94 00
4	10/21/2011			15		D2931	Stainless Steel Crown	140 00
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee: 444 00

35. Remarks: If TPL involved: write the words "Carrier Paid" and enter the amount paid by the TPL here.

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____ Patient/Guardian signature _____ Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____ Subscriber signature _____ Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment [ ] Provider's Office [ ] Hospital [ ] ECF [ ] Other
39. Number of Enclosures (00 to 99) Radiograph(s) [ ] Oral Image(s) [ ] Model(s) [ ]
40. Is Treatment for Orthodontics? [ ] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code:
XYZ Dental Group
8956 No Cavity Ave.
Smiley, LA 700000
49. NPI: 1987654321
50. License Number
51. SSN or TIN
52. Phone Number: (222)999-4444
52A. Additional Provider ID: 1234567

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X Mary Cleanteeth — Signed (Treating Dentist) — 11/18/2011 — Date
54. NPI: 1234567890
55. License Number: 99999
56. Address, City, State, Zip Code
56A. Provider Specialty Code
57. Phone Number ( ) -
58. Additional Provider ID: 1987654

Family Planning (Take Charge)

- Program effective October 1, 2006
- Requirements
  - Females ages 19-44
  - Enrollees exempt from Community Care and do not need a referral
  - White Identification Card
  - Check Eligibility!

Family Planning (Take Charge)

- Services can be rendered by physician, nurse practitioner, or physician assistant
- Limited Services
  - Yearly physical exams and necessary re-visits
  - Laboratory test
  - Medication and supplies i.e. birth control, patches, IUD's, etc.
  - Some voluntary sterilization procedures covered
- Lamedicaid.com for the complete listing of service codes

Electronic Data Interchange (EDI)

- Preferred method of submitting Medicaid claims to Molina
- Methods of EDI submission:
  - via telecommunications
- Advantages of submitting EDI
  - Increased cash flow
  - Improved claim control
  - Faster payment turnaround

Electronic Data Interchange (EDI)

- Certification Forms
  - Must be renewed at the end of every calendar year
  - Must have current EDI annual certification of electronically submitted Medicaid claims on file
  - **Failure to submit the annual certification form will result in deactivation of the submitter#, thus affecting your payment**
- Enrollment requirements
- Electronic adjustments/voids

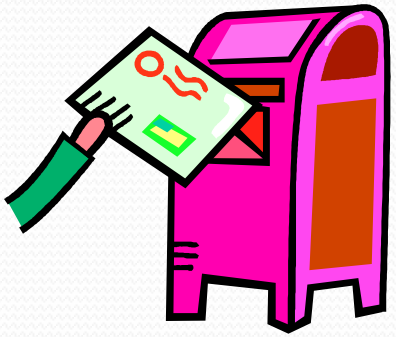
Electronic Data Interchange (EDI)

Submission Deadlines

- Regular business weeks
  - KIDMED Submissions (All media) 4:30 p.m. each Wed.
  - Telecommunications 10:00 a.m. each Thurs.
- Thanksgiving Week
  - KIDMED Submissions (all media) 4:30 p.m. Tues., 11/22/11
  - Telecommunications 10:00 a.m. Wed., 11/23/11

Hard Copy Requirements

- Certain claims will always require hard copy billing
- Hard copy claims with attachments must be submitted to the appropriate P.O. Box



Timely Filing Guidelines

All claims must be filed within 12 months of the date of service

- KIDMED claims that are not received for processing within the 60 day time period will receive the educational EOB edit 435 as a reminder to the provider that the claims should be submitted within 60 days of the date of service.
- Providers should strive to submit KIDMED claims within 60 days in order for the claims to be adjudicated, and allow paid claims to be reflected on all reports.

Two-year Override Consideration

- Providers requesting two-year overrides for claims
  - Must provide proof of timely filing
  - Must meet criteria
  - Must be sent to Molina Provider Relations Correspondence Unit with a letter of explanation.

- Address:

  Molina – Correspondence Unit

  P.O. Box 91024

  Baton Rouge, La 70821

New Check Write Schedule SFY 2012

(July 1, 2011 – June 30, 2012)

- New policy being phased in through the remainder of the fiscal year.
- Currently adjusting payment dates one or two working days in most months, allows providers time and notice to adjust to the new payment schedule.
- New Payment Date calendar can be found on **www.lamedicaid.com**
- No Checkwrite/payments for Thanksgiving week & week of February 27, 2012.

NOTE: Plans to add an additional 14-20 days to claims processing cycle by the end of the year.

Online Remittance Advice

- Weekly paper (RAs) are now online and available in downloadable and printable PDF format.
- RAs will only be available online.
- The most recent five weeks of RAs will be kept online. Providers must download & save or print a copy.
- Located on the secure side of **www.lamedicaid.com**
- Effective November 1, 2011, Medicaid stopped printing and mailing paper Remittance Advices
- You will need a login and password for each provider number that receives an RA.

* *This change has no impact on electronic RAs (835 transactions) and that process remains the same.*

5010 HIPPA Electronic Transactions

- Effective January 1, 2012
- We are testing provider files at this time
- In less than 60 days, all implementation for the 5010 compliance should be completed.
- Providers should be working with their billing entities to ensure that they will be ready with Molina at the appropriate time.
- For updates, check **www.lamedicaid.com**.

Medicaid Eligibility Card Changes

- Effective August 1, 2011, Louisiana Medicaid began issuing only white ID cards to all Medicaid enrollees regardless of the Medicaid program or scope of the benefits package.
- Providers are reminded to always verify Medicaid eligibility and coverage limitations or restrictions prior to providing services.
- Eligibility can be verified by either logging into the **www.lamedicaid.com** MEVS application or calling the Recipient Eligibility Verification System (REVS): 800-776-6323 or 225-924-5040.

Provider Assistance

Molina Provider Relations Department
Phone: (800) 473-2783
(225) 924-5040

Molina EDI Department
Phone: (225) 216-6303

Molina Provider Enrollment
Phone: (225) 216-6370

Molina Web Technical Support Help Desk
Phone: (877) 598-8753

Field Analyst Listing on Web Site
(www.LaMedicaid.com)

Fraud and Abuse Hotline

Any individual or provider may report possible cases of fraud or abuse

- Phone:
  - 1-800-488-2917

- Web Address:
  - http://www.dhh.louisiana.gov

Louisiana Medicaid Website Applications

www.lamedicaid.com

- Provider login and password
- Web applications
  - e-MEVS
  - e-CSI
  - e-CDI
  - e-PA
  - Weekly Remittance Advice
- Provider Enrollment applications online

Other Helpful Websites

- Additional DHH available websites
  - WWW.LA-KIDMED.COM
  - WWW.LA-CommunityCARE.COM

- Louisiana Department of Education
  - http://www.doe.state.la.us/divisions/specialp/school_medicaid.html

Thank You

For Attending This 2011 Provider Workshop